Public Performance Report
July – September 2017

West Dunbartonshire
Health and Social Care Partnership

Introduction

Welcome to West Dunbartonshire Health and Social Care Partnership's second Public Performance Report for 2017/18.

Building on our Strategic Plan for 2016-2019 we are committed to providing clear and transparent updates on our progress in key priority areas; on an ongoing basis.

More information about Health and Social Care Partnership services is available on our website at www.wdhscp.org.uk.

We are always keen to receive feedback, so whether you want to provide constructive comments on the contents of this report or any of our services more generally, please contact us at www.wdhscp.org.uk/contact-us/headquarters/.

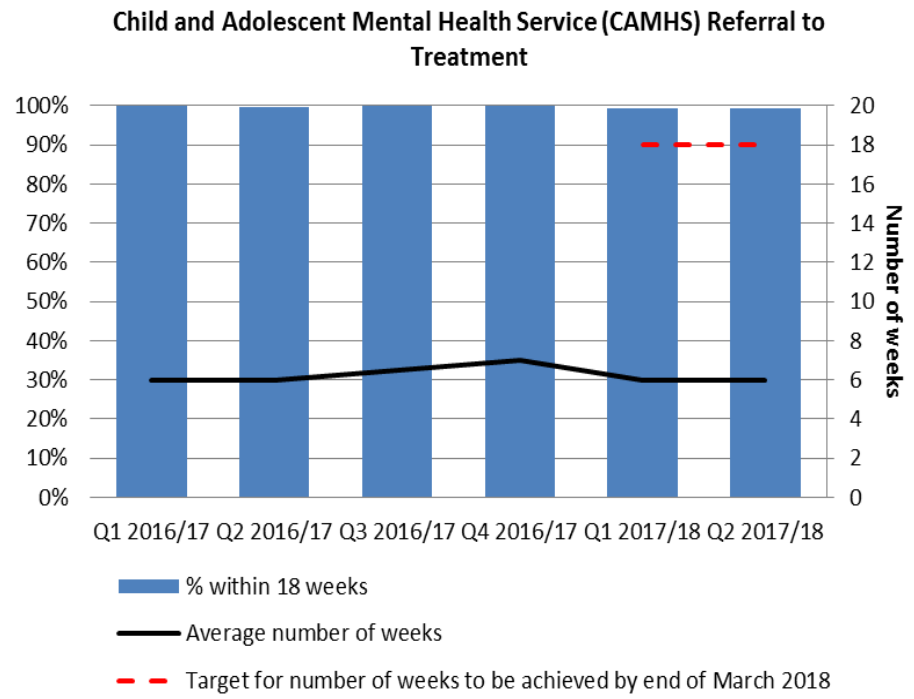
Mr Soumen Sengupta

Head of Strategy, Planning & Health Improvement

The West Dunbartonshire Health and Social Care Partnership Board's:

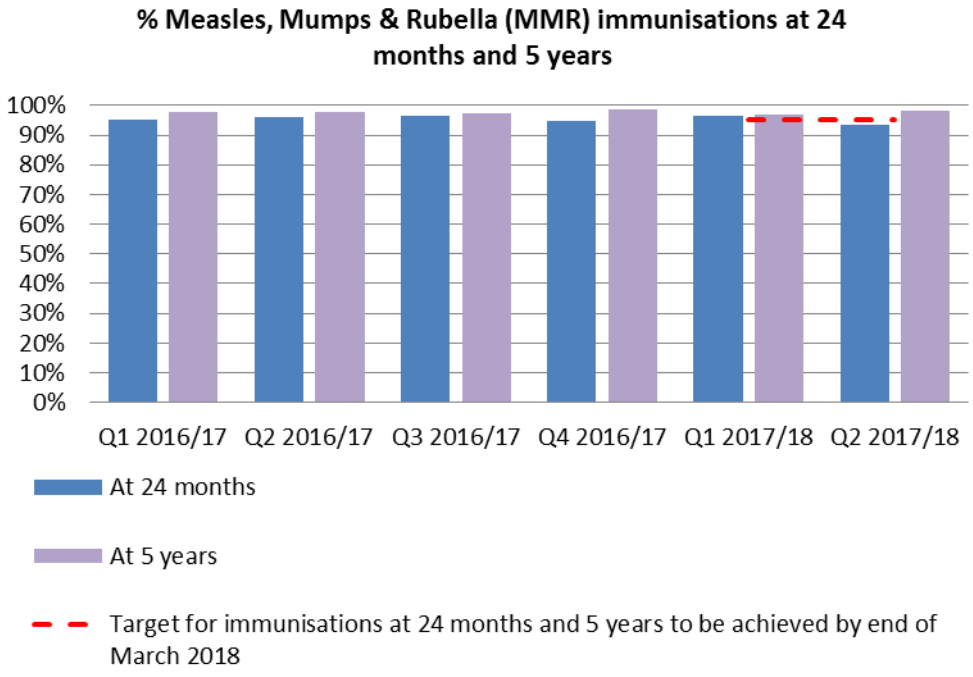
- **Mission is to improve the health and wellbeing of West Dunbartonshire.**
- **Purpose is to plan for and ensure the delivery of high quality health and social care services to and with the communities of West Dunbartonshire.**
- **Core values are protection; improvement; efficiency; transparency; fairness; collaboration; respect; and compassion.**

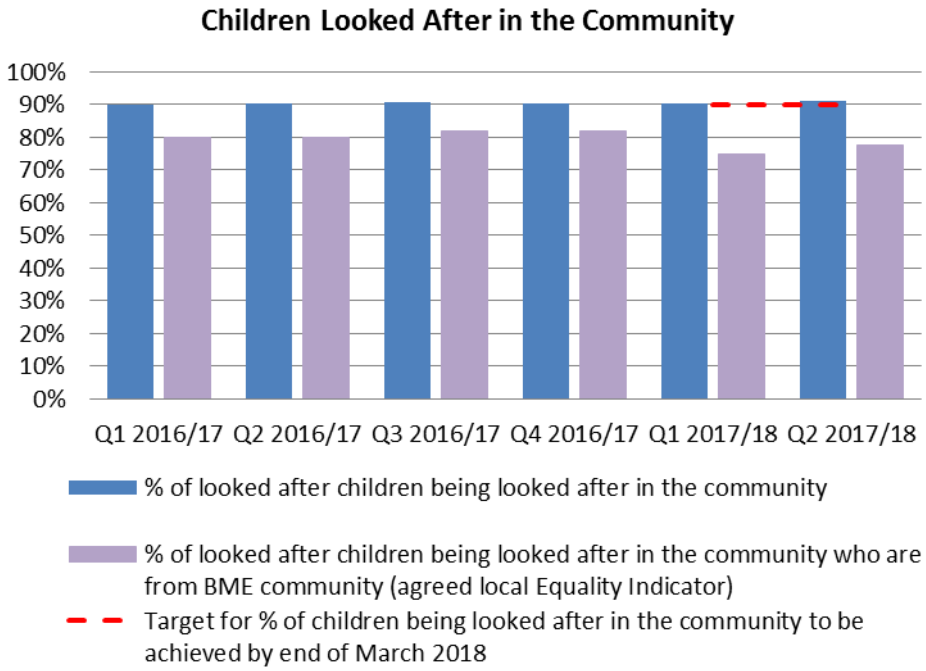
Supporting Children and Families



85 children and young people were referred to CAMHS in Qtr2 2017/18, a reduction of 17 on the previous quarter. The average time for referral to treatment continues to be well below the 18 week target at 6 weeks.

221 children had an MMR immunisation at 24 months (93.6%) and 278 children had an MMR immunisation at 5 years (98.2%) in Qtr2 2017/18.



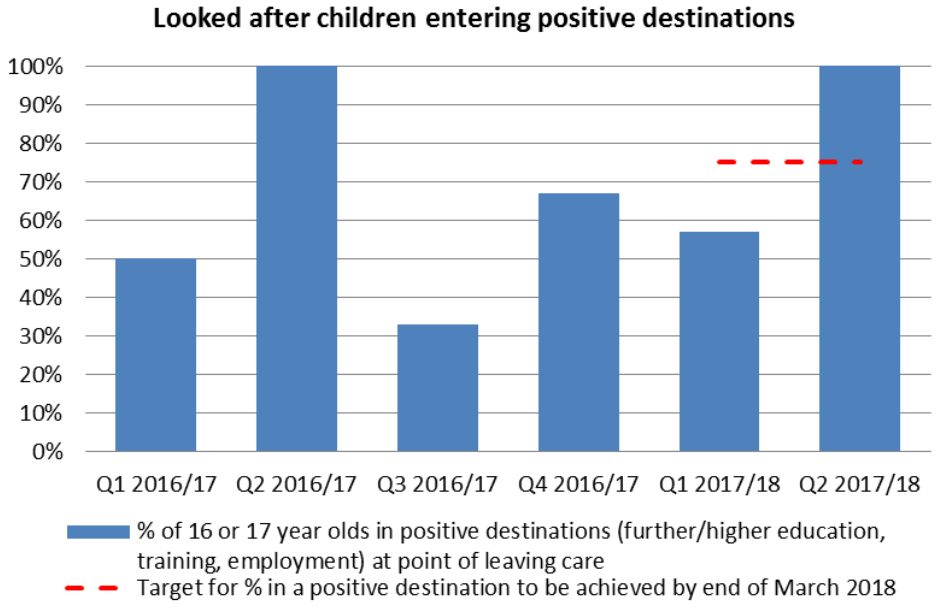


402 of the 441 looked after children were looked after in the community (91.2%) in Qtr2 2017/18.

Of the 9 looked after children who happened to be BME (Black & Minority Ethnic), 7 were looked after in the community (77.8%) in Qtr2 2017/18.

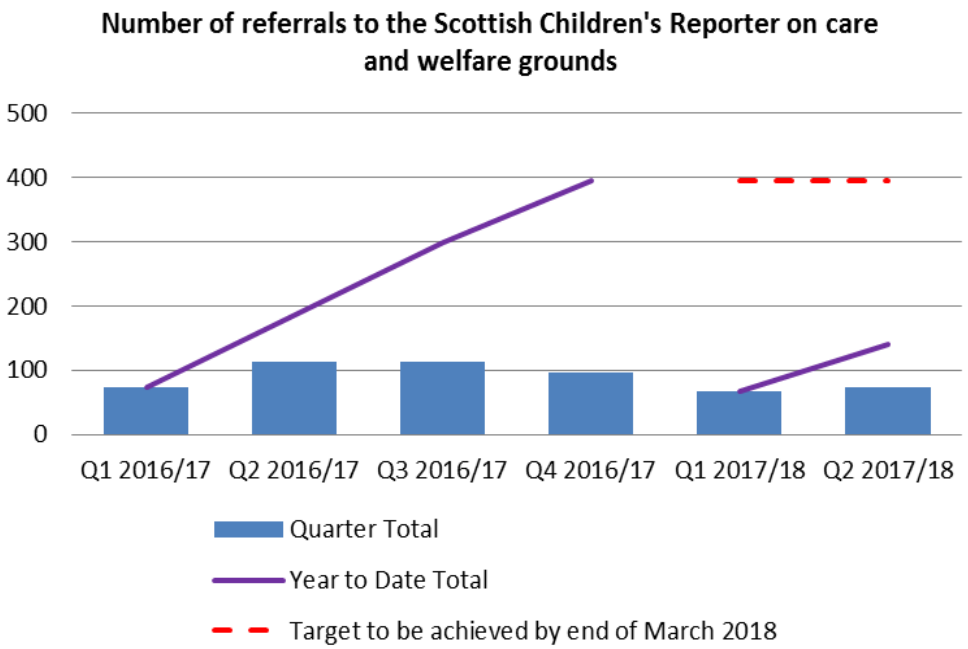
All of the children (100%) who left care in Qtr2 2017/18 entered a positive destination.

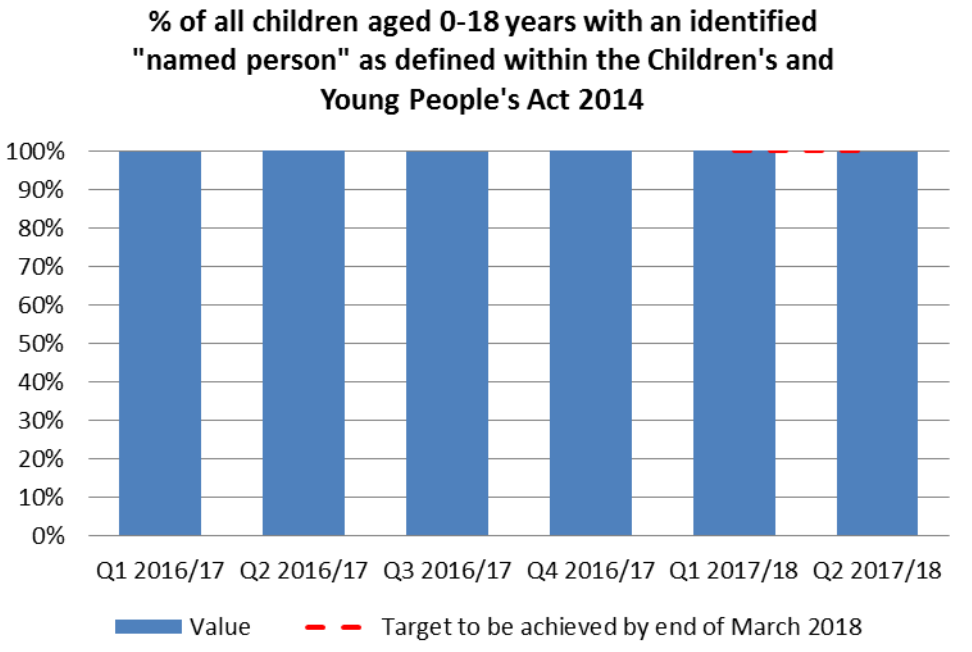
This indicator relates to a very small number of children and therefore the percentage can fluctuate significantly.



* 2016/17 quarterly figures revised at year end

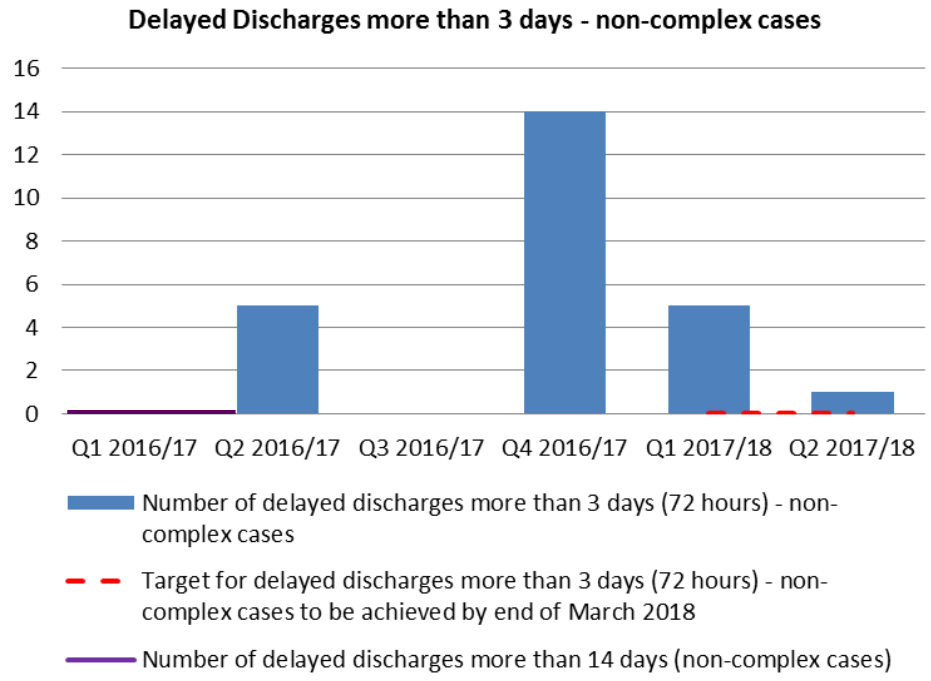
67 children were referred to the Scottish Children's Reporter (73 referrals) on care and welfare grounds during Qtr2 2017/18.





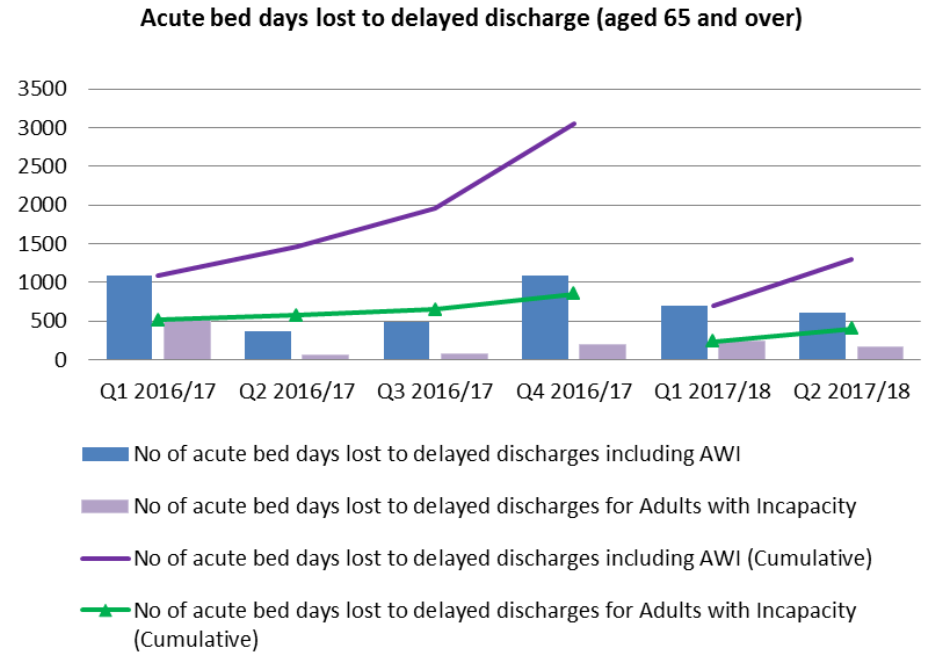
18,652 children (99.7%) had an identified named person in Qtr2 2017/18.

Supporting Older People



The Scottish Government changed the way delayed discharges are counted from 1st July 2016. The previous figure for delays of more than 14 days has been included in the chart for context/ comparison.

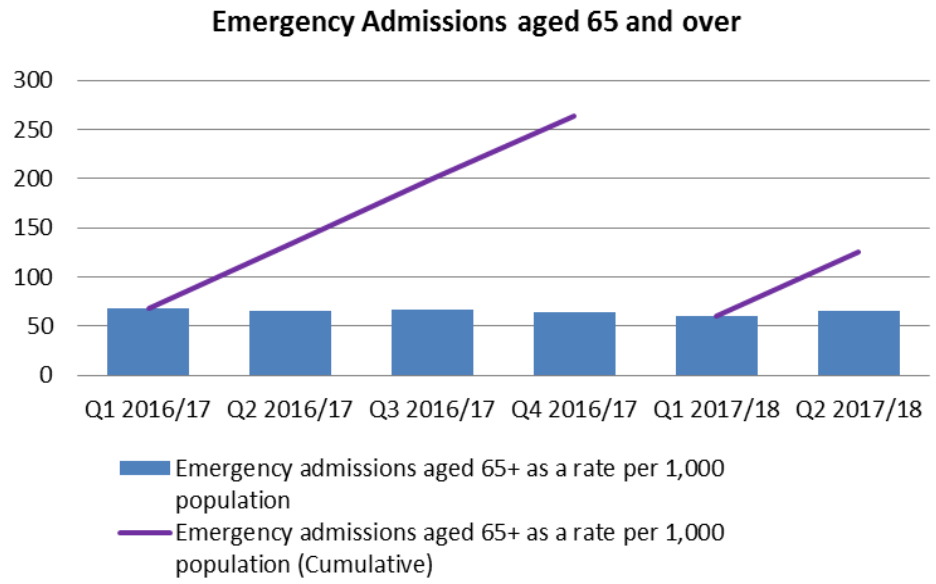
There was 1 delay of more than 3 days for non-complex cases at the census point in Qtr2 2017/18.



603 bed days were lost to delayed discharge for people aged 65 and over in Qtr2 2017/18. 162 of these bed days were lost to delayed discharge for Adults with Incapacity (AWI).

During the same period in 2016/17, there were 374 bed days lost, 57 of which were for AWI.

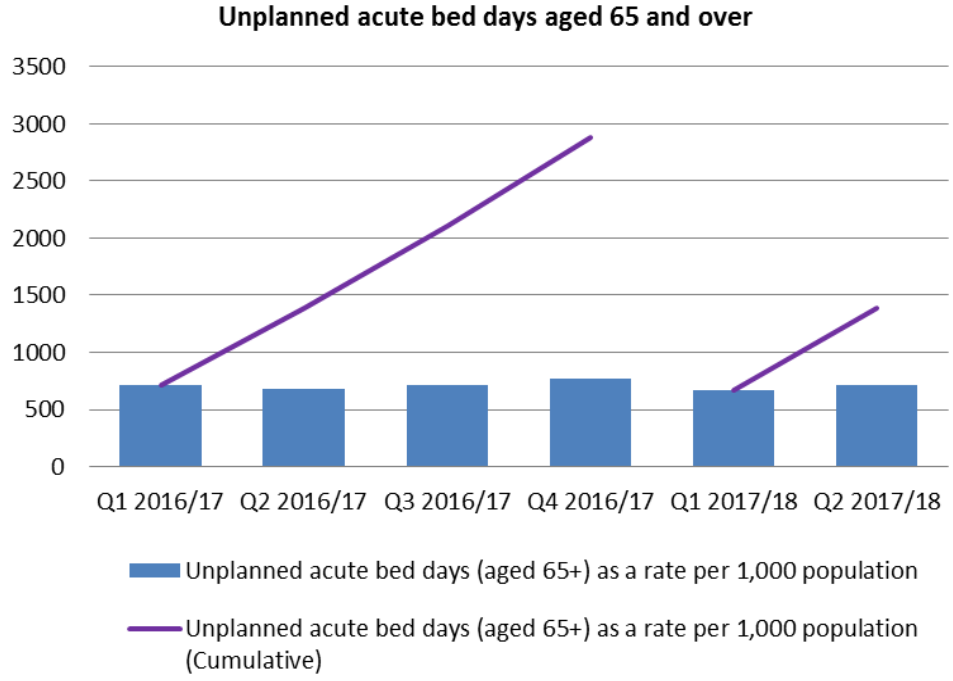
Targets will be set in line with the local objectives agreed with the Ministerial Strategic Group for Health and Community Care (MSG).



There were 1,040 emergency admissions of people aged 65 and over in Qtr2 2017/18: a rate of 65 per 1,000 population.

During the same period in 2016/17, there were 1,032 emergency admissions: a rate of 65 per 1,000 population.

Targets will be set in line with the local objectives agreed with the Ministerial Strategic Group for Health and Community Care (MSG).

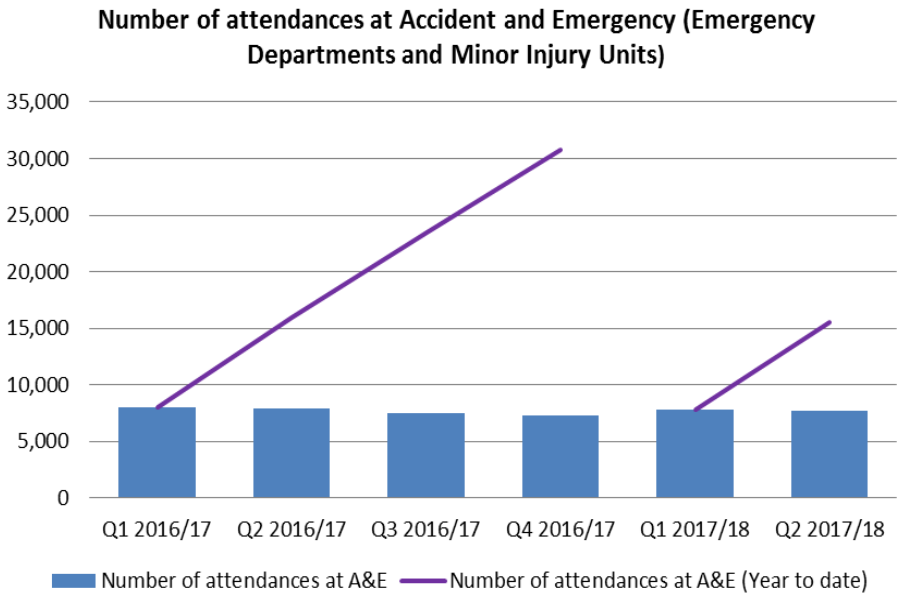


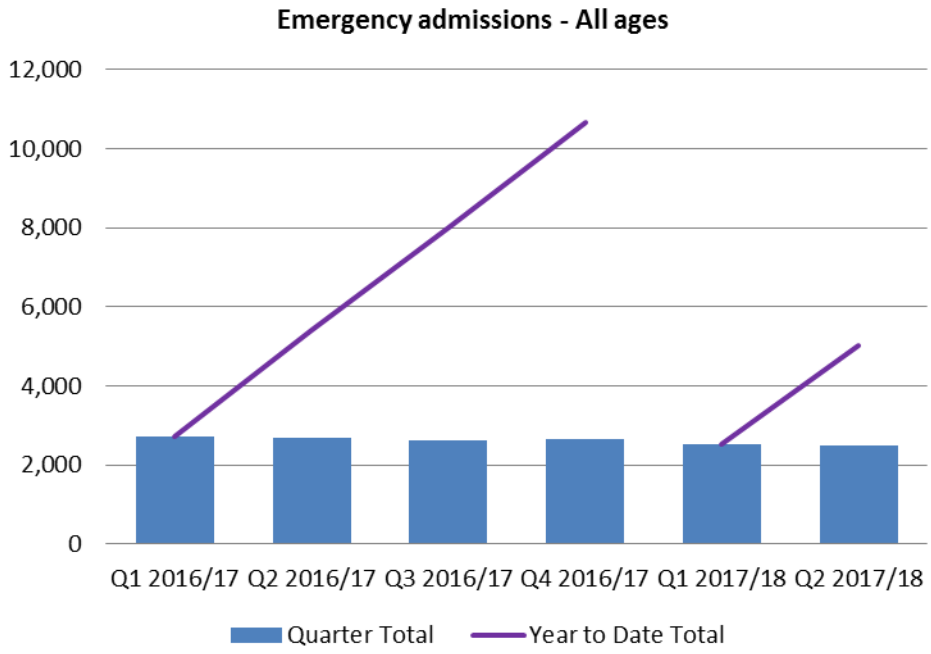
There were 11,357 unplanned acute bed days used by people aged 65 and over in Qtr2 2017/18: a rate of 715 per 1,000 population.

During the same period in 2016/17, there were 10,733 unplanned acute bed days used: a rate of 675 per 1,000 population.

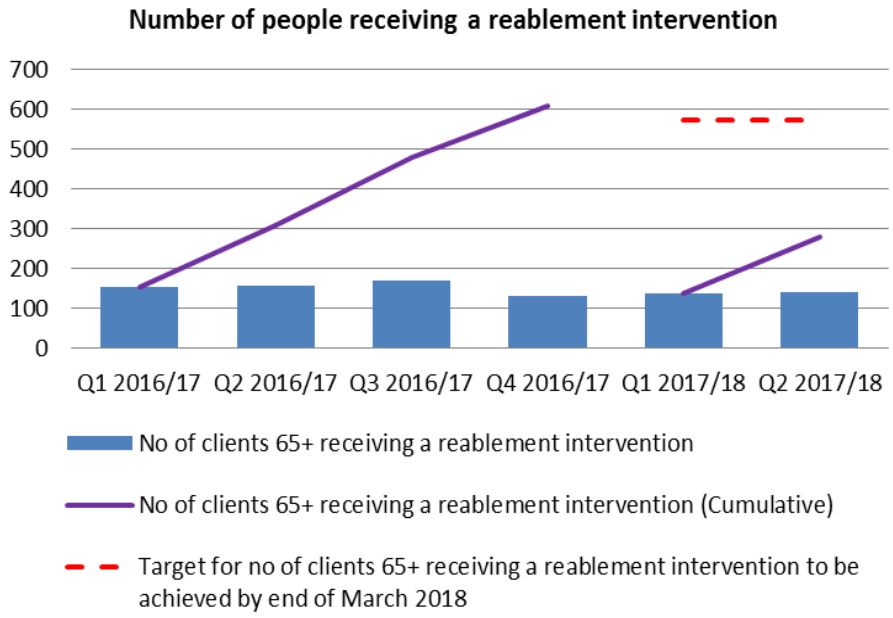
Targets will be set in line with the local objectives agreed with the Ministerial Strategic Group for Health and Community Care (MSG).

Numbers of attendance rather than rates of attendance is being reported in line with the monitoring of our Unscheduled Care objectives. There were 7,721 attendances at A&E in Qtr2 2017/18.
During the same period in 2016/17, there were 7,924 attendances.
Targets will be set in line with the local objectives agreed with the Ministerial Strategic Group for Health and Community Care (MSG).

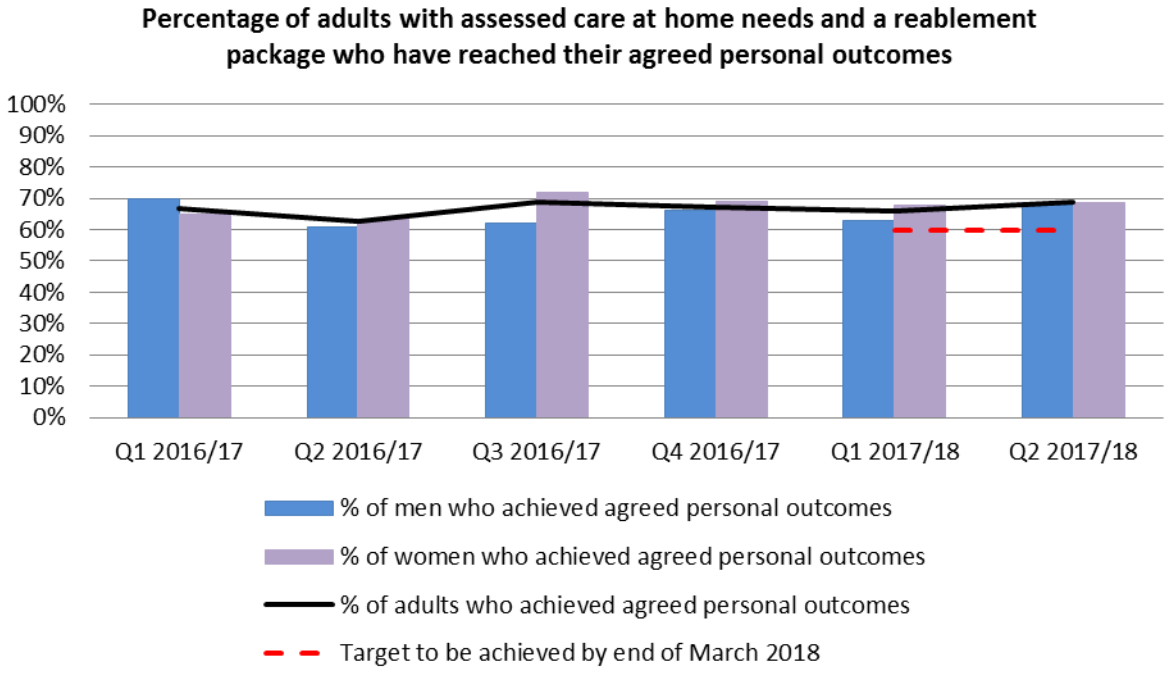


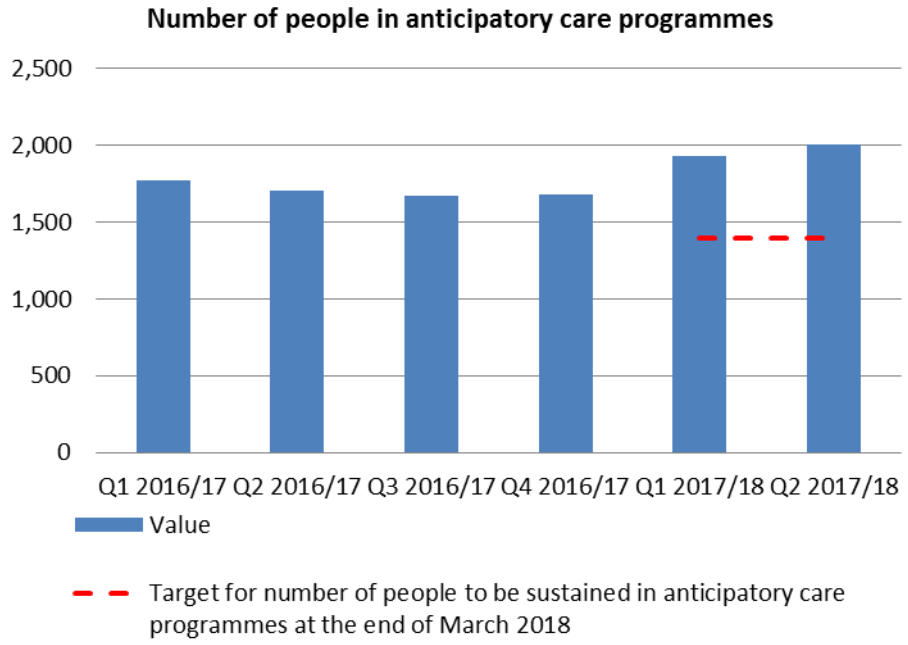


There were 2,492 emergency admissions (all ages) in Qtr2 2017/18.
During the same period in 2016/17, there were 2,692 admissions.
Targets will be set in line with the local objectives agreed with the Ministerial Strategic Group for Health and Community Care (MSG).



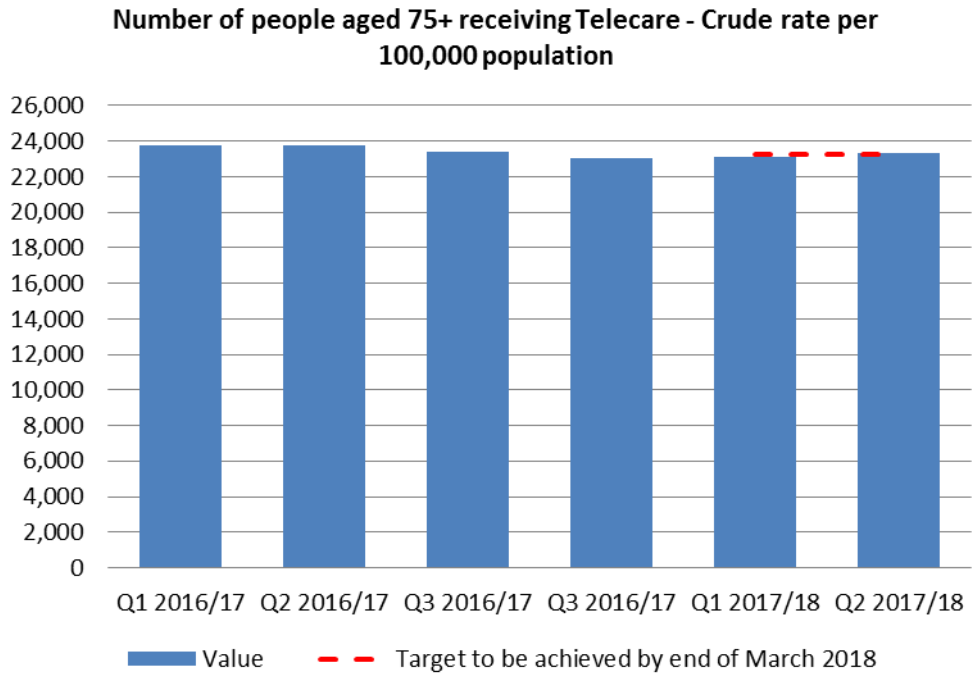
97 of the 141 people (68.8%) who received a reablement service achieved their agreed personal outcomes in Qtr2 2017/18: 68.8% of men and 68.8% of women.

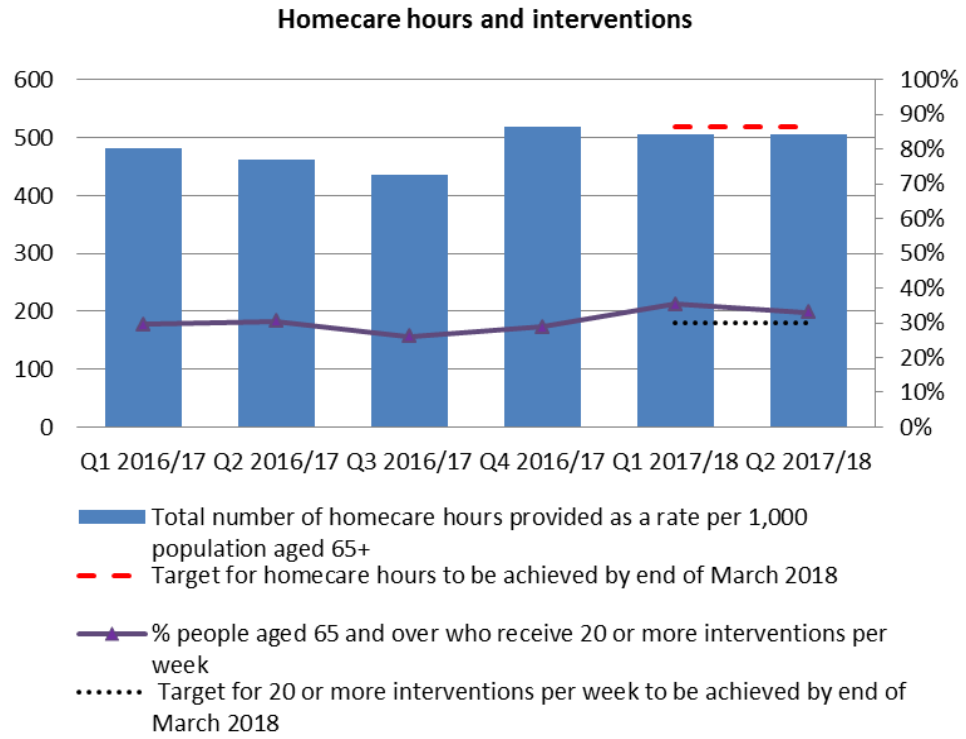




2,003 people had an Anticipatory Care Plan (ACP) in place in Qtr2 2017/18. This figure now includes both GP-led and ACP Support Nurse ACPs.

1,645 people aged 75 and over received a Telecare service at the end of Qtr2 2017/18.



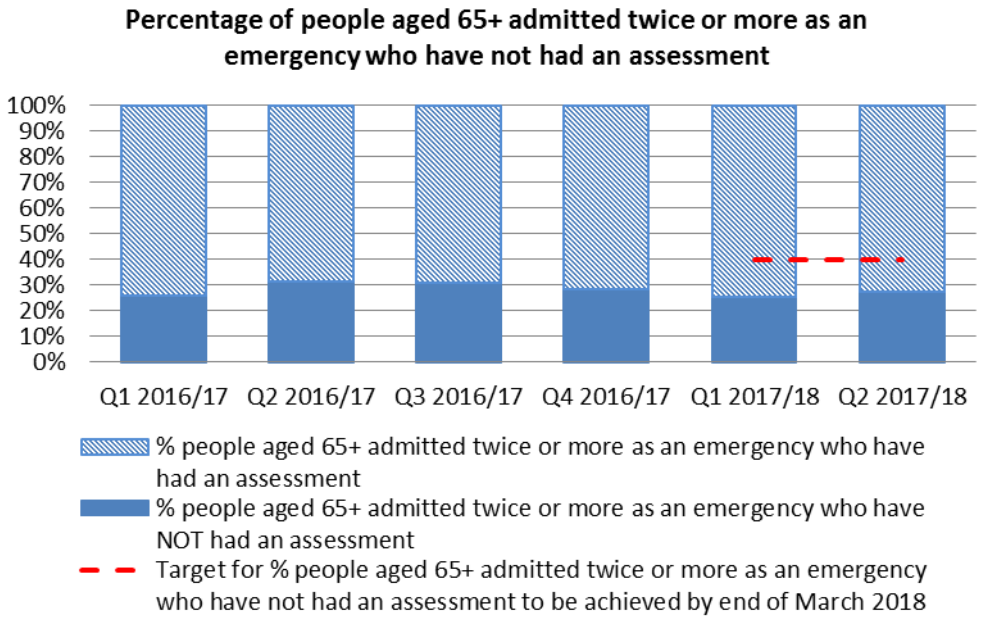


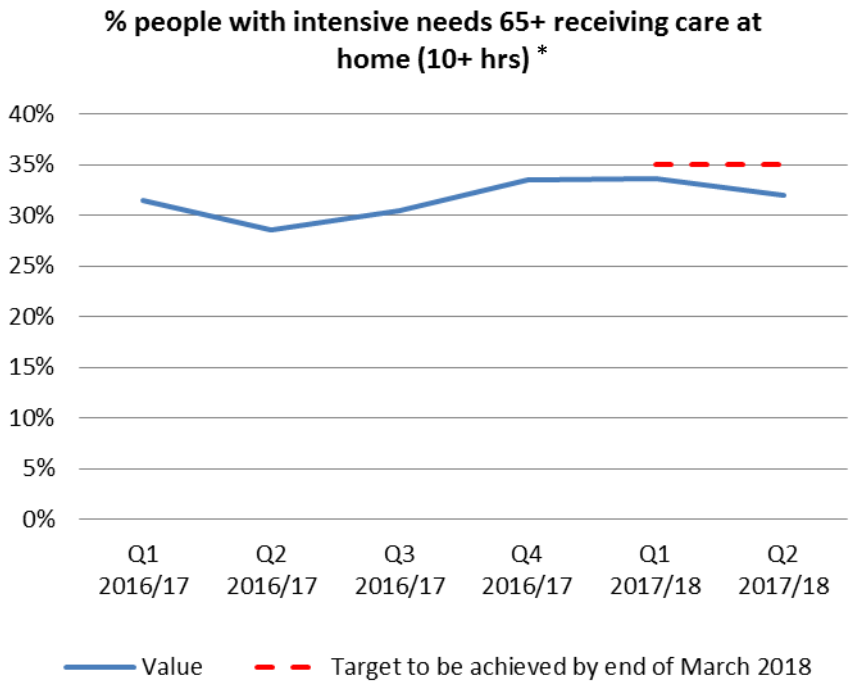
8,190 hours of homecare per week were provided to 1.317 people aged 65 and over in Qtr2 2017/18. This equates to a rate of 505.8 hours per 1,000 population.

436 people received 20 or more interventions per week (33.1%) in Qtr2 2017/18.

621 people (72.3%) aged 65 and over admitted to hospital twice or more received an assessment of their needs in Qtr2 2017/18.

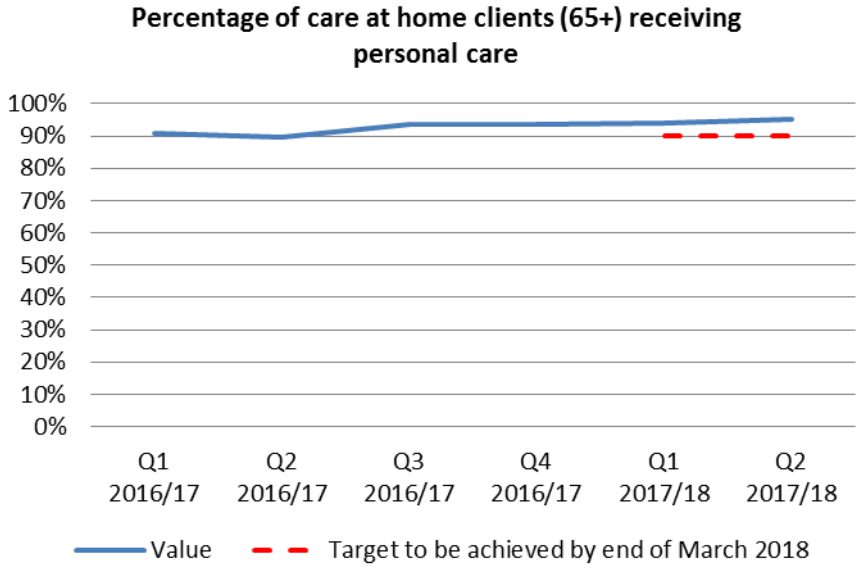
238 people (27.7%) did not have an assessment.





284 people aged 65 and over with intensive needs received 10 or more hours of care at home in Qtr2 2017/18.

This indicator is published by the Local Government Benchmarking Framework and measures volume of home care in isolation from other services. People with the most intensive needs receive complex packages of care utilising a range of community supports including home care, meal deliveries, day care, community health input and Telecare. These supports combine to reduce the reliance on traditional high volumes of home care and provide a more targeted response to the person's needs.

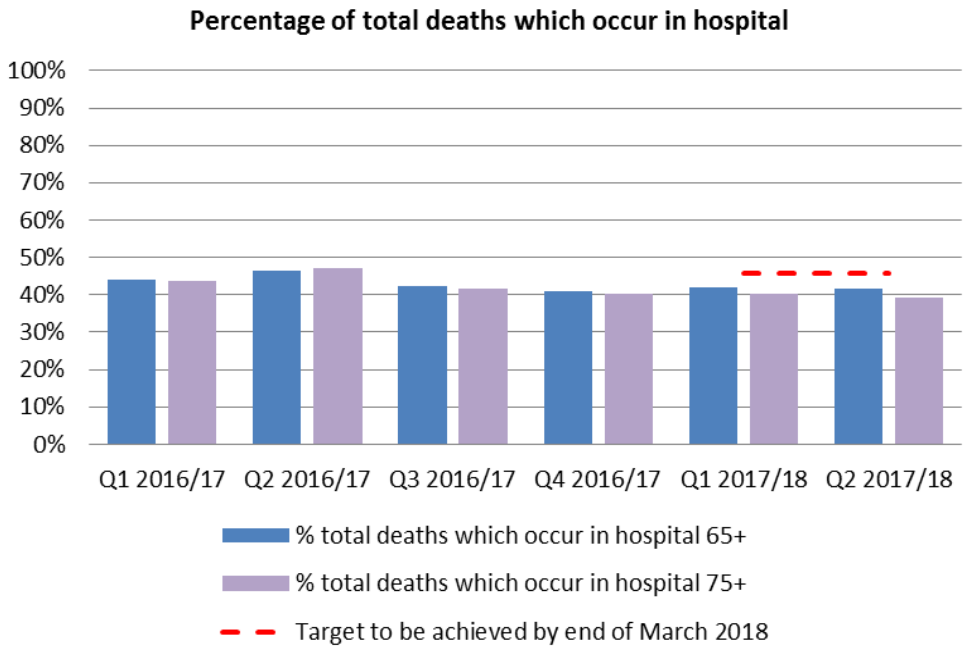


1,253 of 1,317 people (95.1%) aged 65 and over received personal care at home in Qtr2 2017/18.

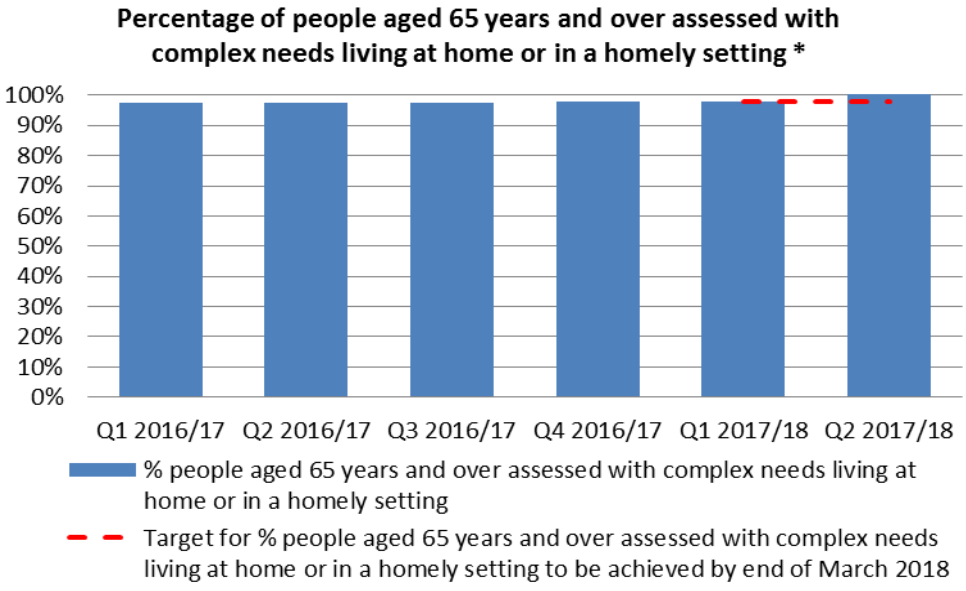
*A change in the 2015/16 guidance for the collection of Continuing Care data will affect comparability with previous figures. Scottish Government are currently examining options to resolve this and this may result in an update to the data presented here.

41.7% of all people aged 65 and over who died in Qtr2 2017/18 died in hospital.

39.4% of those aged 75 and over died in hospital: the lowest percentage since January 2011.



868 people (97.7%) aged 65 and over with complex needs were living in a homely setting in Qtr2 2017/18.



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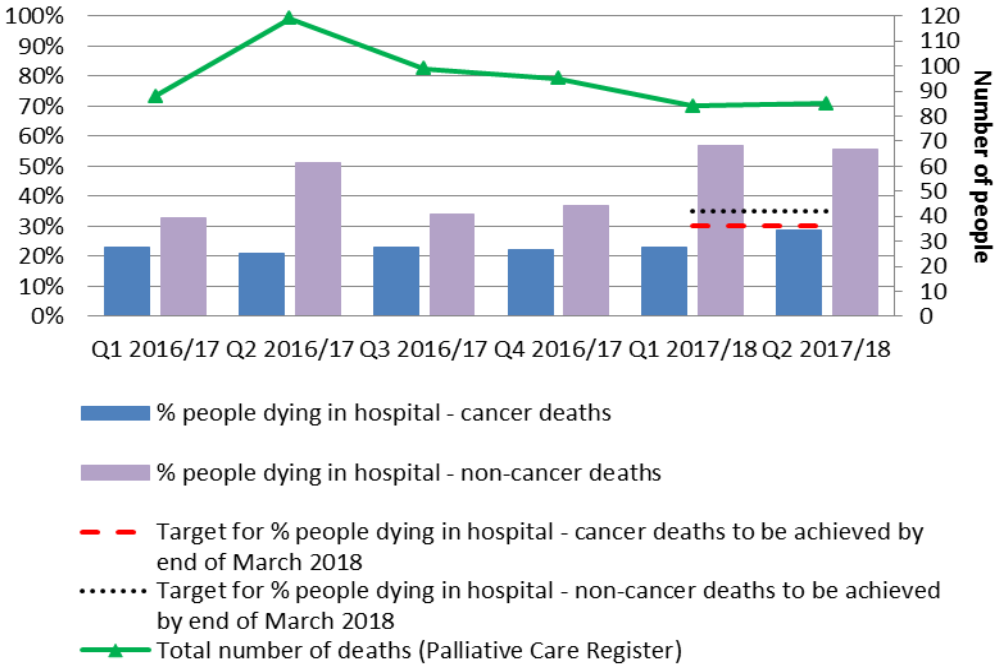
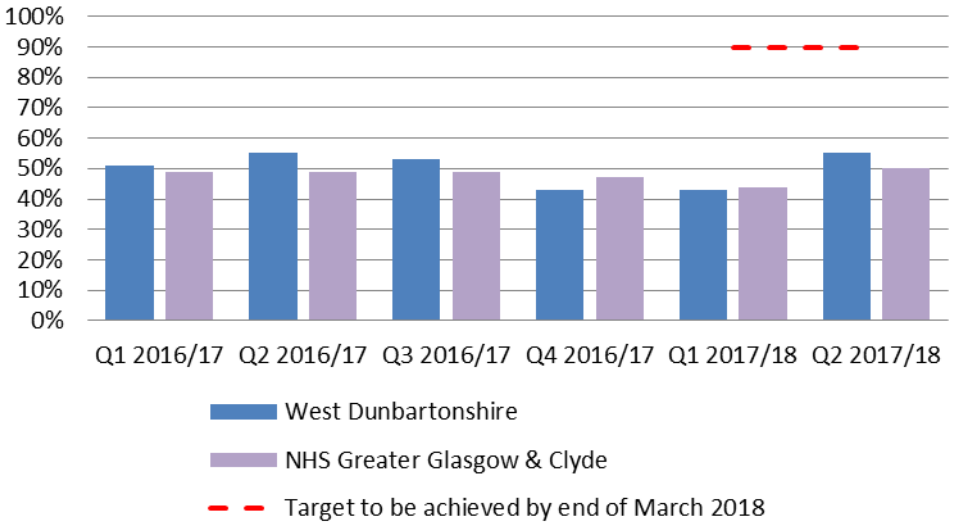
Percentage of people on the Palliative Care Register dying in hospital

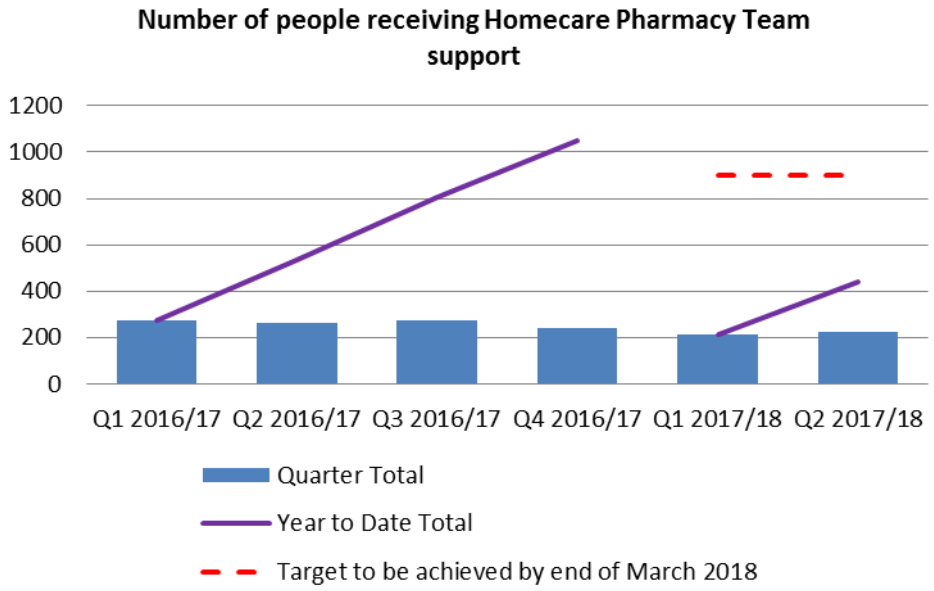


85 people on the Palliative Care Register died in Qtr2 2017/18, 60% of whom were supported to die at home or in a homely setting.

1,610 people from West Dunbartonshire and 17,795 from across NHS Greater Glasgow & Clyde were referred to the MSK service in Qtr2 2017/18.

Percentage of people seen within 4 weeks for musculoskeletal physiotherapy (MSK) services

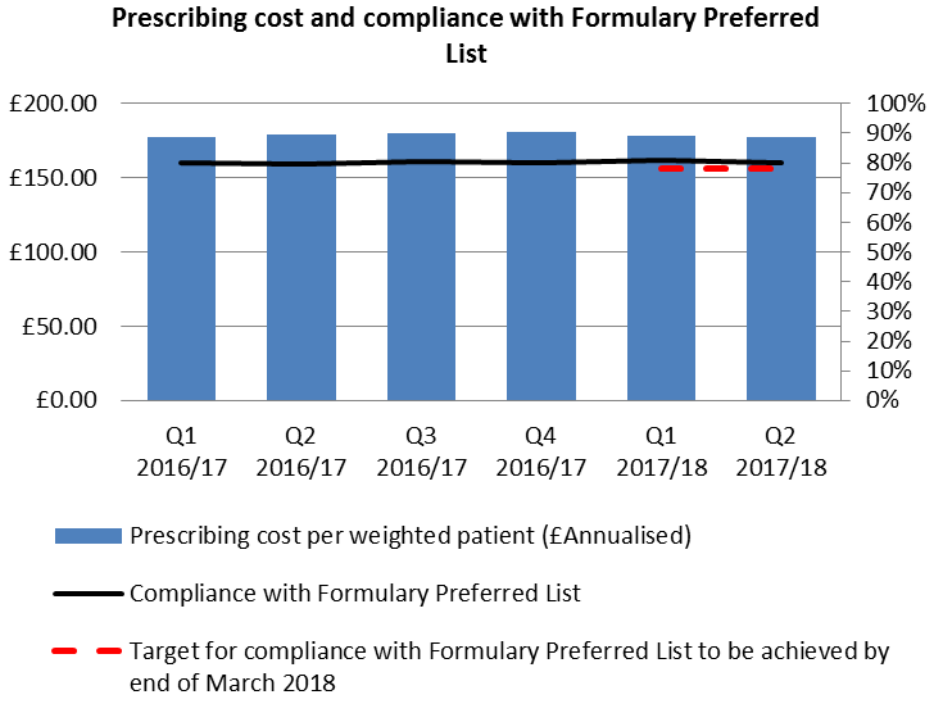


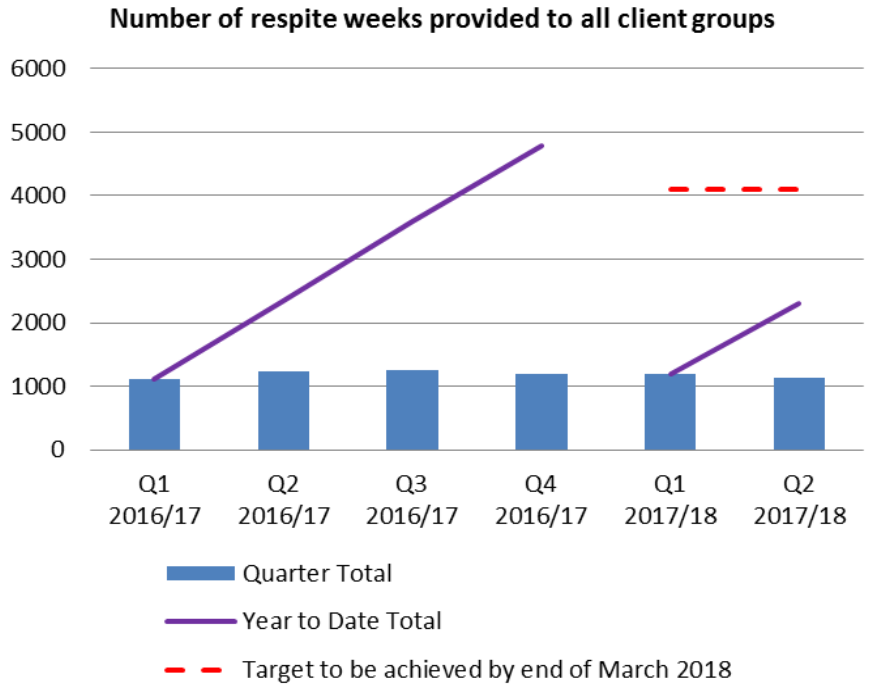


443 people were referred to the Homecare Pharmacy Team in Qtr2 2017/18. 89 people declined the support and 100 people were being supported by other service teams.

Compliance with the Formulary Preferred List was 80% in Qtr2 2017/18.

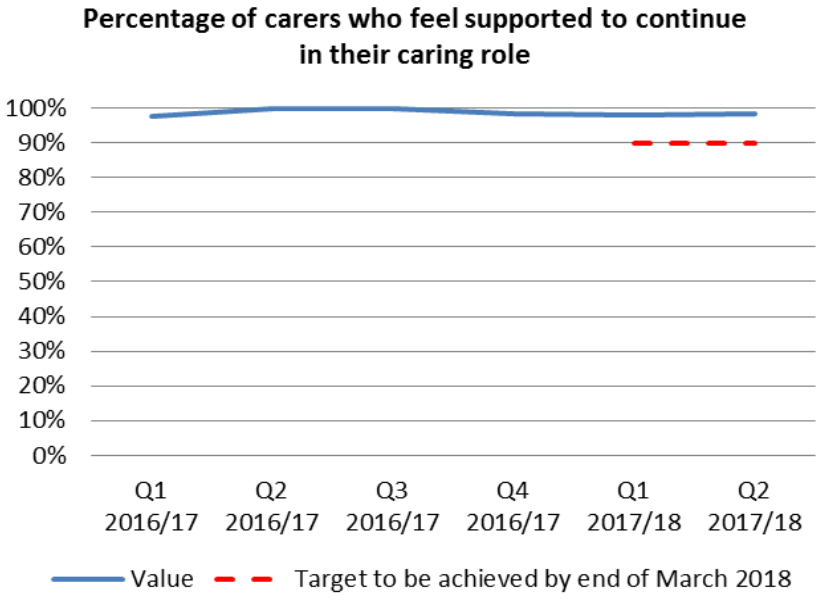
WDHSCP's prescribing cost target is the average cost across NHS Greater Glasgow & Clyde as calculated at the end of March 2018.



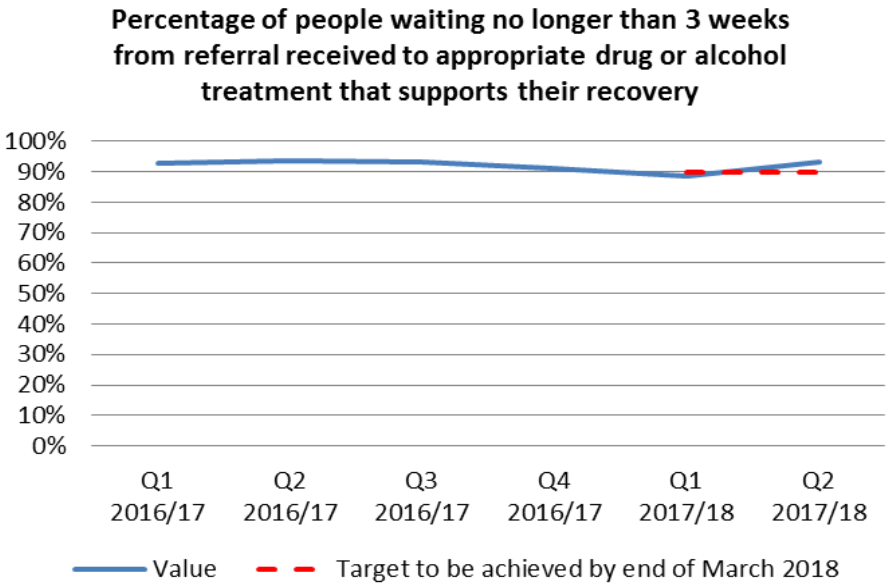


406 people received respite in Qtr2 2017/18. Targets have been reviewed in light of a revised methodology for inclusion of respite which must now be clearly identified in the cared for person's care plan.

66 of the 67 carers (98.5%) asked as part of their Carer Support Plan felt supported to continue in their caring role during Qtr2 2017/18.

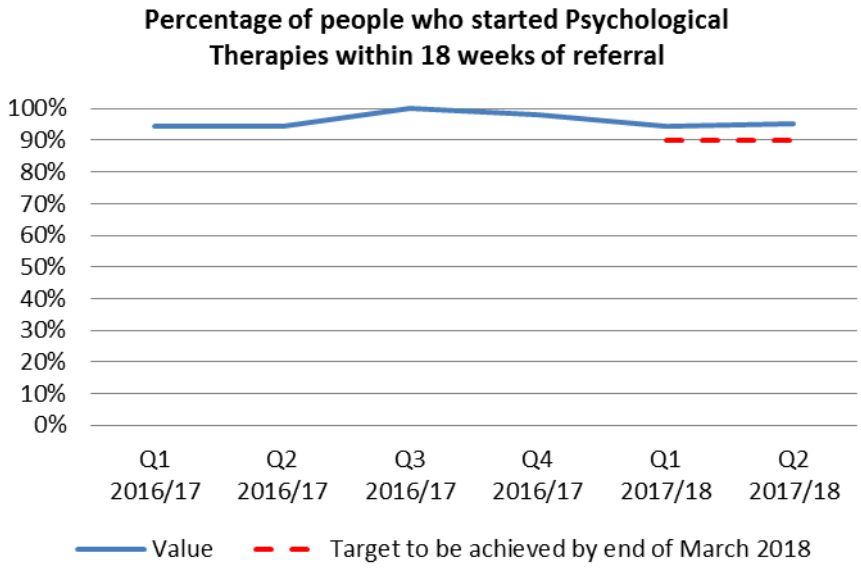


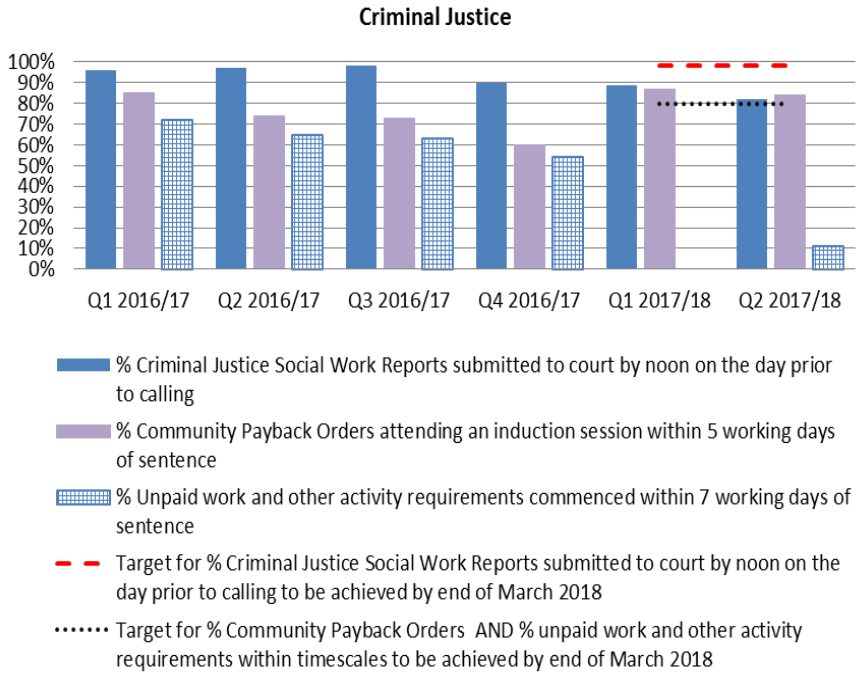
Supporting Safe, Strong and Involved Communities



214 of 229 people (93.4%) received treatment within 3 weeks of referral in Qtr2 2017/18.

62 of 65 people (95.4%) started Psychological Therapies treatment within 18 weeks of referral in Qtr2 2017/18.



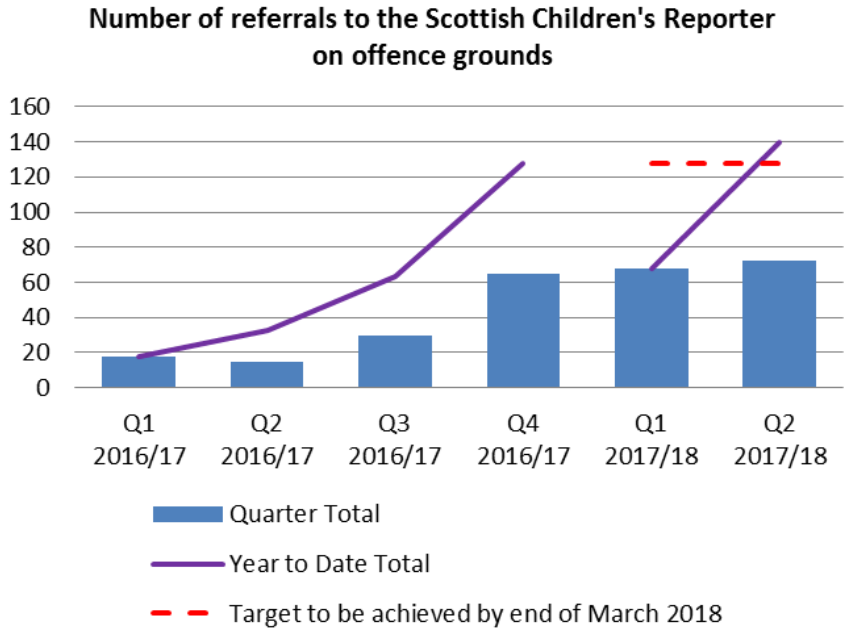


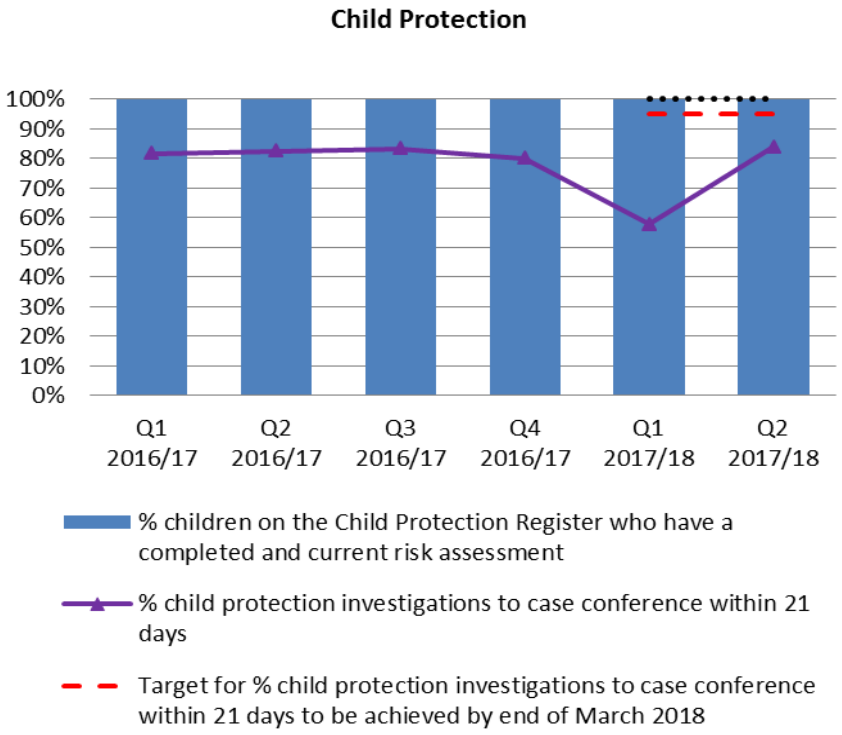
103 of the 125 (82%) Social Work Reports were submitted on time in Qtr2 2017/18.

75 of the 89 (84%) new Community Payback Orders attended induction within the timescale in Qtr2 2017/18.

8 of the 75 (11%) of unpaid work orders were commenced within 7 days in Qtr2 2017/18. Work is underway to understand and address this poor performance. A high volume of new unpaid work orders and 2 vacant posts may have been contributing factors.

28 children were referred to the Scottish Children's Reporter (72 referrals) on offence grounds during Qtr2 2017/18.

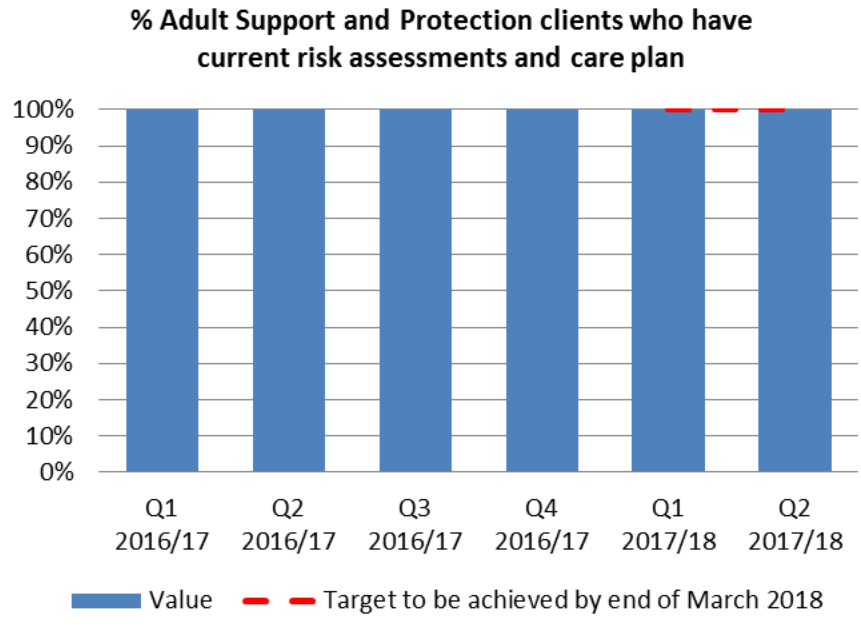




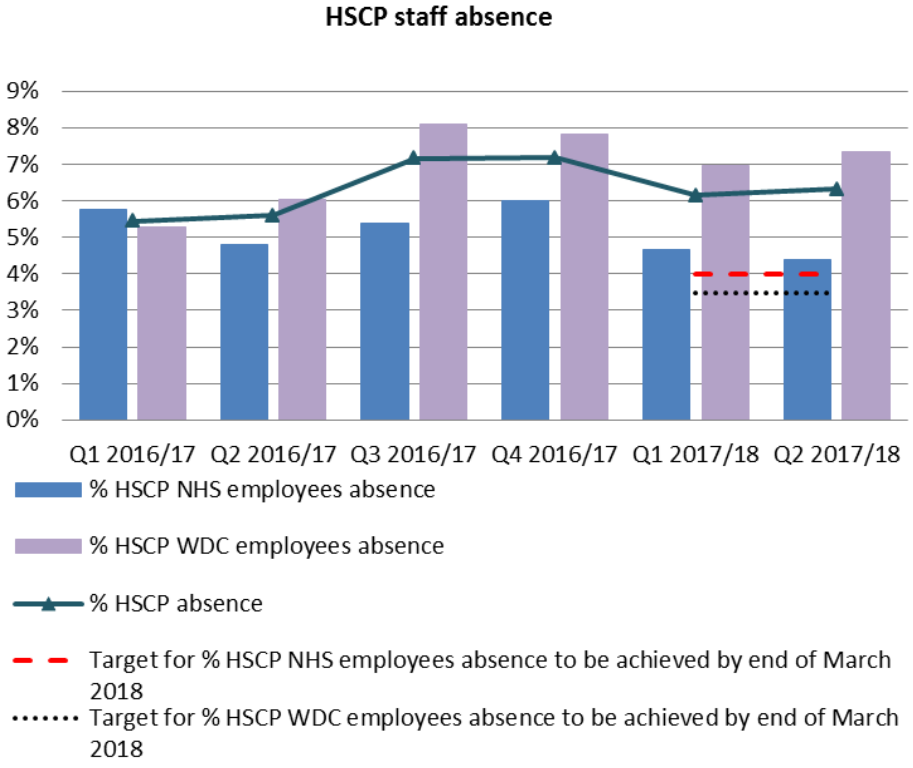
There were 55 children on the Child Protection Register at the end of Qtr2 2017/18.

42 out of 50 (84%) case conferences were carried out within 21 days during Qtr2 2017/18. Performance is being closely monitored to address any impact of higher registration numbers.

All 5 Adult Support and Protection clients had a current risk assessment and care plan in Qtr2 2017/18.

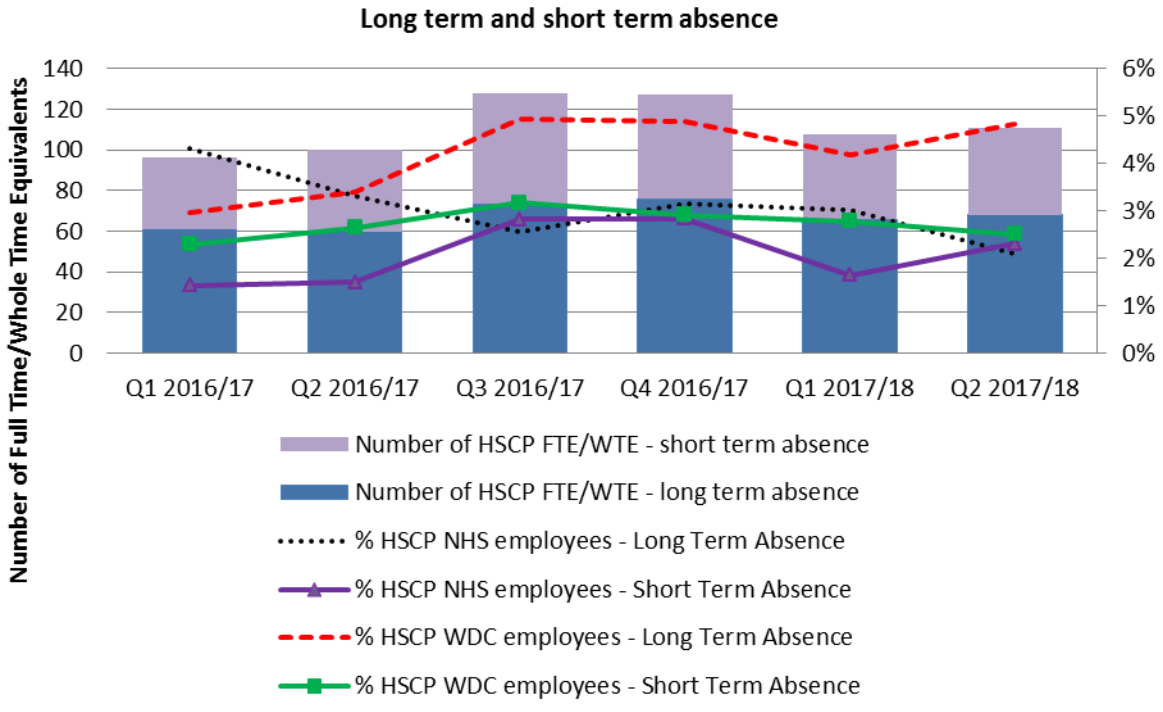


Our Staff

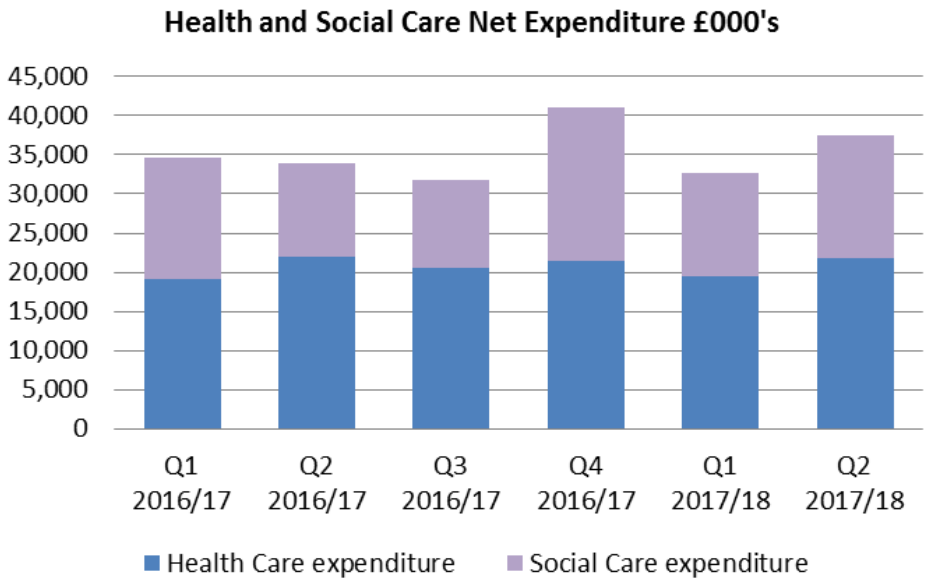


There were 728 NHS employees (608.62 Whole Time Equivalent) and 1,422 WDC employees (1144.33 Full Time Equivalent) working within the HSCP during Qtr2 2017/18.

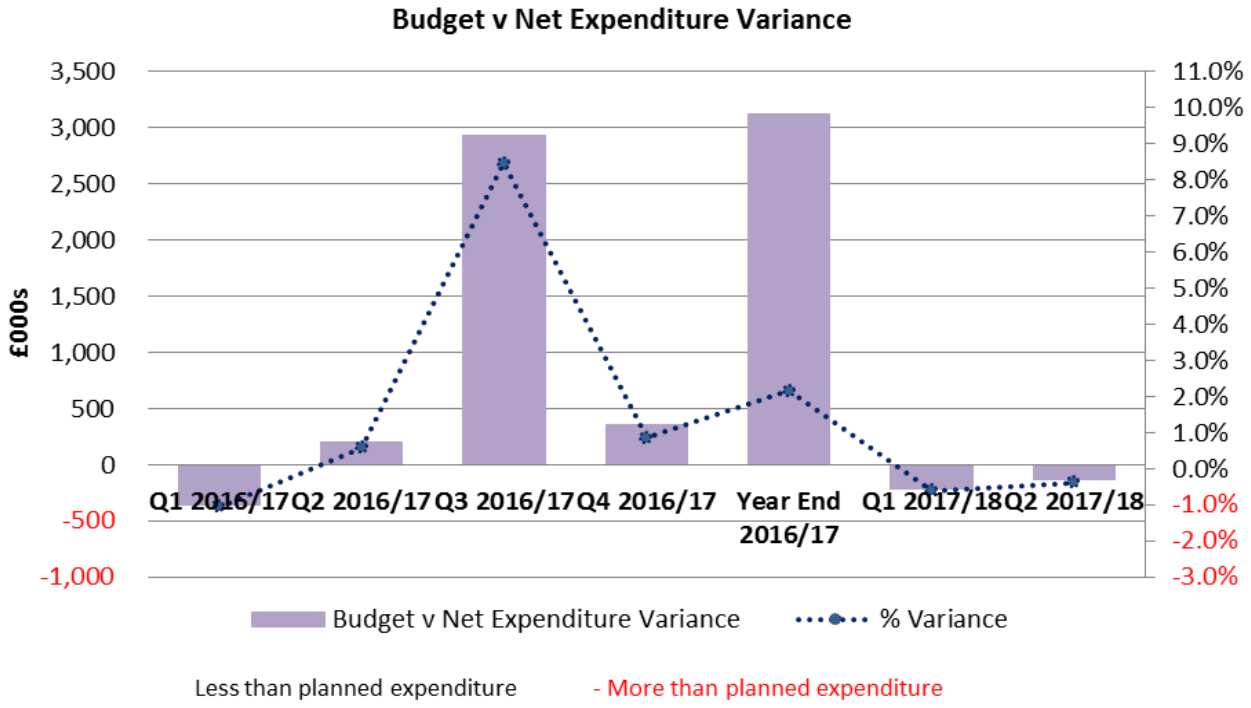
Overall HSCP absence was 6.32% in Qtr2 2017/18: 7.34% WDC employees and 4.4% NHS employees.



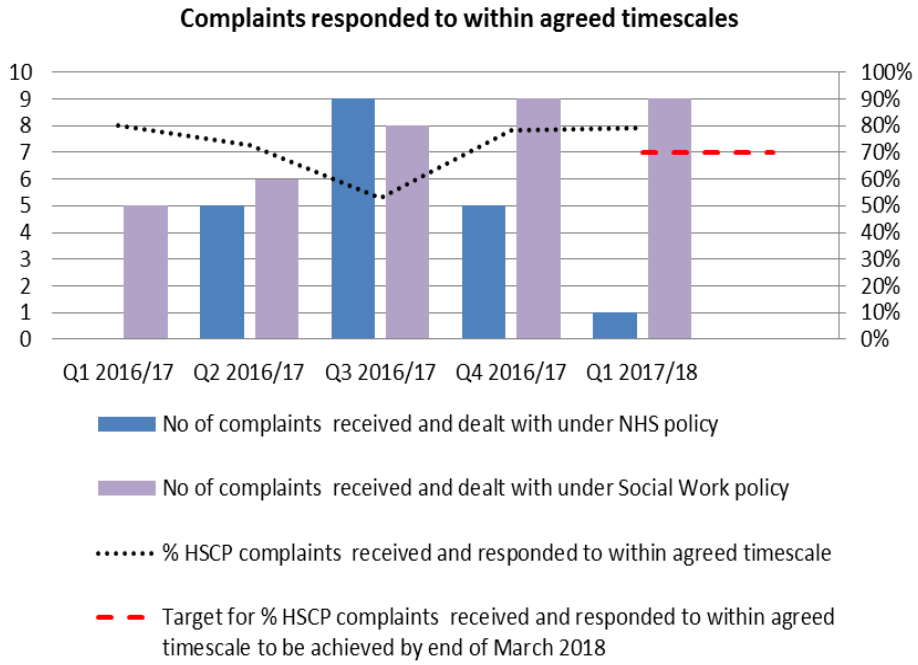
Our Finance



HSCP Expenditure to the end of September 2017 of £70.32m against a budget of £69.97m (not including Set-Aside).

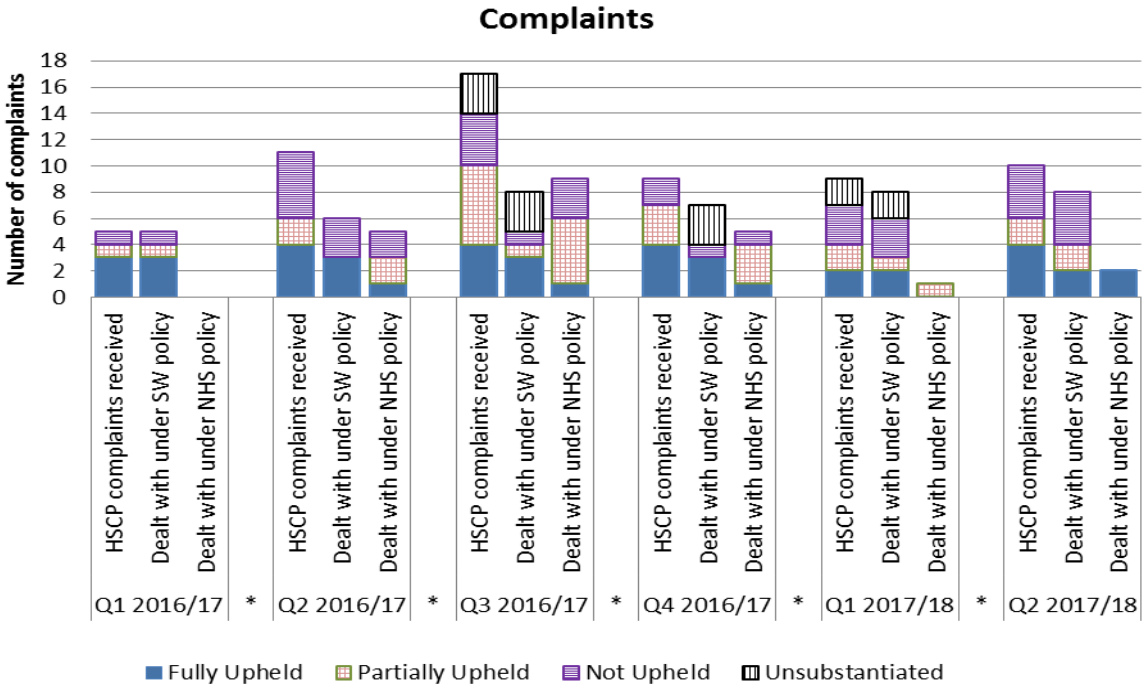


Complaints



6 complaints were dealt with through the Social Work Complaints policy and 2 through the NHS policy in Qtr2 2017/18.

3 complaints were responded to outwith the timescales. These were between 2 and 10 days late and were due to administrative delays.



Of the 4 upheld complaints in Qtr2 2017/18, 2 concerned Employee Conduct, 1 Employee Attitude/Communication and 1 Service Delivery. Any learning from these complaints is being considered within the relevant service areas.

Service Improvement Linked to Performance

Community Telehealth and Telecare: Chronic Obstructive Pulmonary Disease

Within West Dunbartonshire the prevalence of people with Chronic Obstructive Pulmonary Disease (COPD) is 3.02% compared to 2.57% in Greater Glasgow and Clyde and numbers continue to increase. Our COPD Nursing Service is a targeted approach to reducing the impact of COPD. West Dunbartonshire HSCP is combining the use of telehealth with telecare (community alarm) for patients with COPD and since January 2017 the community COPD Nursing Service has offered patients combined telecare and telehealth monitoring.

"It's great, I feel I have extra support to stay at home particularly when my chest is bad."

Mrs M (76) has managed her COPD well, with good family support enabling her to continue to live at home alone for over 12 years. However in the last year her condition has deteriorated and she has required additional support from the COPD Nursing Service. Combining telehealth and telecare in one package, Mrs M now uses the Florence system in combination with a community alarm to better self-manage her COPD: giving her the knowledge that nursing staff are only a text away if she needs them during the day; and that her community alarm provides extra support and assurance, particularly during evenings and weekends. She knows that the community alarm staff understand her condition, have received specific training and will use a bespoke algorithm to ensure that she gets help when she needs it.

"We are less anxious now knowing my mum is able to get a nurse or carer support with a text or press of a button".

Previously Mrs M would have contacted NHS 24 or emergency services during an exacerbation, but by using Florence and the Community Alarm together she and her family have felt more secure for her to stay at home. Clinically, this supports starting treatment without delay and assists with better symptom management. Daily contact during these periods enables her to be maintained safely in the community with a variety of support options at any time of day or night. Since commencement in early 2017 Mrs M has had 3 exacerbations successfully managed at home by the COPD Nursing Service without interventions from secondary care or attendance at A&E.

Celebrating Success recognition for Residential Care for Older People

Residential Care and Day Services for Older People won the HSCP Award for 'Delivering a new model of Residential Services for Older People' at this year's NHSGG&C Celebrating Success Awards. Phil MacDonald (Integrated Operations Manager, Residential and Day Services) and Margaret Kelly (Care Manager, Crosslet House) received the award from our Chief Officer, Beth Culshaw and NHS GGC Chief Executive, Jane Grant. Phil said "It's great that our team is being recognised for the hard work being put in to improve the services for our residents". The project redesign has already seen the successful migration of residents from our old care homes and day services in Dumbarton, into the new Crosslet House building in Dumbarton. The next phase of the project is the build of the Clydebank Care Home at Queen's Quay, scheduled to open in 2019.

For more information on our services and their performance please visit
http://www.wdhscp.org.uk/about-us/public-reporting/